STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155698	A. BUILDING 00 B. WING	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY POINTE HEALTH CAMPUS	1707 BETHANY RD ANDERSON, IN46012

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F0000	This survey was for Recertification and State Licensure Survey. Survey Dates: June 27, 28, 29, and 30, 2011 Facility Number: 011045 Provider Number: 155698 AIM Number: 08110451 Survey Team: Tammy Alley RN TC Toni Maley BSW Donna M. Smith RN Karen Lewis RN (June 27, 28 and 29, 2011) Census Bed Type: SNF: 55 SNF/NF: 15 Residential: 32 Total: 102 Census Payor Type: Medicare: 32 Medicaid: 10 Other: 60 TOTAL: 102 SAMPLE: 15 RESIDENTIAL SAMPLE: 7	F0000	Submission of this Plan of Correction does not constitute an admission by Bethany Pointe Health Campus of any wrong doing or failure to comply with Federal or State Regulations. Moreover, the allegations contained in this statement of deficiencies are not a true or accurate portrayal of the provision of nursing care or the services of this facility. This provider wishes this plan of correction be considered as our allegation of compliance.The provider respectfully requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. .	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/6/11 Cathy Emswiller RN			

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F0157 SS=E	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician when a resident's condition changed in a manner that might require a change in treatment, for resident with abnormal blood sugars, residents who had emesis (vomiting), residents who had medications held for low blood pressures	F0157	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident #52 and #44 records reviewed to ensure MD notification is in place for any high / low blood sugar readings per MD ordered parameters. Resident #16 record reviewed to	07/30/2011

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	for 4 of 15 residents reviewed for physician notification when indicated in a sample of 15 (Residents #52, #44, #54 & #16) Findings include: 1.) Resident #52's record was reviewed on 6/27/11 at 10:45 a.m. Resident #52's current diagnoses included, but were not limited to, diabetes mellitus, hypertension. Resident #52 was admitted to the facility on 6/15/11. Resident #52 had current, 6/15/11, physician's orders for: a.) accuchecks (blood sugar checks) before breakfast, before lunch, before supper and at bedtime. b.) notify the physician if the resident's blood sugar results was less than 60 or greater than 400. A review of Resident #52's accucheck record and nursing notes indicated the following incidents of low blood sugar when the doctor was not notified as follows: a.) 6/16/11 before breakfast a result of 52. b.) 6/16/11 before supper a result of 44. c.) 6/18/11 before supper a result of 49.		ensure MD notification is in place for any noted episodes of emesis. Resident #54 record reviewed to ensure MD is notified prior to holding any medication.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Record review for past 7 days of residents with accucheck orders to ensure MD notification for high / low readings per parameters is documented, if indicated. 24 hour report review for past 7 days for any documented episodes of emesis. If indicated, will review resident's record to ensure MD was notified. Medication administration record review for past 7 days for resident's receiving antihypertensive medications to ensure MD was notified if medication was held.3. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will review campus guidelines for physician notification with licensed nurses. The Medication Administration Record will be changed in that all diabetic orders will now appear on different colored paper and the order for MD notification per parameters will be listed with the accucheck order. Diabetic orders will be listed on the same page for licensed nurses to initial. 4. How the corrective action will be	

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	d.) 6/22/11 before breakfast a result of 50. e.) 6/22/11 before supper a result of 51. 2.) During a 6/29/11, 1:40 p.m., interview, the Director of Nursing indicated the facility did not have any documentation or additional information to provided regarding physician notification or lack there of regarding the above low blood sugars. 3. The record for Resident # 44 was reviewed on 6/29/11 at 10 a.m. Current diagnoses included, but were not limited to, Diabetes. Physician orders for June 2011 indicated the physician was to be notified of blood sugar results less than 70 and greater than 400. Original date of order was 7/23/10.		monitored to ensure the alleged deficient practice does not recur: Medical Records or designee will audit the medication administration records for MD notification of high / low blood sugar readings per MD ordered parameters. Audit will be completed daily x 2 weeks, then weekly x 2 weeks, then monthly until substantial compliance is obtained. DHS or designee will audit for completed change in condition forms with MD notification related to episodes of emesis and holding of medications. Audits will be completed daily x 2 weeks, then weekly x 2 weeks, then monthly until substantial compliance is obtained. The results of the audits will be presented to the Quality Assurance Committee on a monthly basis until consistent application of the guidelines are noted. Periodic evaluation will be conducted for following applicable guidelines.	

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	The Medication Administration Record for April, May, and June 2011 indicated the following blood sugar results and the record lacked physician notification of the high blood sugars. April 1 at supper blood sugar was 424. May 12 at supper blood sugar was 425. May 26 at supper blood sugar was 455. June 11 at supper blood sugar was 422. June 14 at supper blood sugar was 462. June 16 at supper blood sugar was 497. June 24 at supper blood sugar was 418. On 6/29/11 at 9:30 a.m., additional information was requested from the Assistant Director of Nursing regarding lack of physician notification of the high blood sugars. On 6/29/11 at 2:30 p.m., during interview, the Assistant Director of Nursing indicated the physician was not notified of the high blood sugars. 4. Resident #16's record was reviewed on 6/29/11 at 8:55 a.m. The resident's diagnoses included, but were not limited to, dysphasia, dementia, and left sided hemiparesis. The quarterly minimum data set assessment, dated 4/22/11, indicated the resident made poor decisions requiring			

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	supervision. The resident had a feeding tube. The physician order, dated 1/28/11, was a tube feeding of Osmolite 1.5 at 45 milliliters per hour for 12 hours and was scheduled from 7:00 p.m. to 7:00 a.m. The physician's recap orders, signed and dated 6/14/11, was a pureed diet with honey thick liquids. The "NURSE'S NOTES," dated 6/03/11 at 5:30 p.m., indicated the resident had a large amount of emesis and had eaten 100% of food after being fed by a family member. She had started coughing and had vomited. She did indicate she felt much better after the emesis. No information was indicated concerning the physician being notified. On 6/29/11 at 2:30 p.m. during the daily exit conference, information was requested concerning the lack of physician notification related to Resident #16's emesis episode. On 6/30/11 at 8:30 a.m. during an interview, the Director of Nursing indicated she had no information concerning the physician being notified concerning the episode of Resident #16's emesis.			

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5. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia (stroke), debility, and hypertension.

The physician order, dated 8/19/10, was Amlodipine (Norvasc) 5 milligrams (mg) 1 tablet by mouth every bedtime for hypertension.
The physician order, dated 6/03/10, was Carvedilol (Coreg) 6.25 mg 1 tablet 2 times a day for hypertension.

The "NURSE'S NOTES," dated 3/30/11 at 6:00 p.m., was the resident was awake but tired. Her blood pressure was 103/53. The medications, Norvasc and Coreg, were held due to a low blood pressure. The nurse's notes lacked information concerning physician notification related to the held medications.

On 6/29/11 at 2:30 p.m. during the daily exit conference, information was requested concerning lack of physician notification related to Resident #54's held blood pressure medications.

On 6/30/11 at 8:30 a.m. during an interview, the Director of Nursing indicated she had no information concerning the physician being notified

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	concerning Resident #54's held blood pressure medications. 6. The "PHYSICIAN NOTIFICATION GUIDELINES" guidelines was provided by the Director of Nursing on 6/29/11 at 8:45 a.m. This current policy indicated the following: "Purpose: To ensure the resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care....." 3.1-5(a)(3)			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observations, record review, and interviews, the facility failed to ensure a resident was able to move freely without restraint concerning a self-releasing belt (Resident #51) and positioning in a recliner (Resident #6) for 2 of 4 residents reviewed with restraints in a sample of 15.	F0221	#1 Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident #51 was assessed by the Interdisciplinary Team. Self release alarming belt was discontinued. Implemented personal clip alarm to alert staff of	07/30/2011

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	Findings include: 1. On 6/27/11 at 11:30 a.m., Resident #51 was observed in her wheelchair with her self-releasing alarm belt on. When LPN #3 requested the resident to remove her self-releasing alarm belt several times, the resident was observed to touch her belt and her shirt several times, and then, she said, "no." LPN #3 indicated she was not able to release the belt now. Resident #51's record was reviewed on 6/27/11 at 2:15 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia with hallucinations/delusions. The physician's order, originally dated 4/11/10, was self-releasing seat belt as an enabler to wheelchair to alert staff to attempts at unassisted ambulation. The resident was able to remove belt on command. The "SKILLED NURSING ASSESSMENT AND DATA COLLECTION," dated 5/26/11, indicated the resident's cognitive patterns was "periods of confusion at times." The "Safety and mobility" section indicated no information concerning the resident's self-releasing alarm belt.		unassisted transfers. Resident #6 - the recliner and waste basket were removed from the area. Recliner was found to be defective in that the foot rest would not stay up in the proper position.#2 - Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents with enablers observed to ensure they were able to release their enabler upon command. If unable, the resident will be assessed for reduction in device or coded as restraint if a reduction is not indicated. No other defective recliners are in the campus.#3 - Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will in-service nursing staff on the campus guidelines for Restraint / Enabler use. Residents with self releasing seat belts will be asked to release their belts every shift and will be documented on the medication administration record. The interdisciplinary team will continue to assess all restraints / enablers routinely per campus guidelines#4 - How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will audit medication administration documentation of every shift requesting resident to demonstrate ability to release	

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	The "RESTRAINT/ENABLER CIRCUMSTANCE, ASSESSMENT AND INTERVENTION," dated 3/16/11, indicated this was a quarterly review for the belt alarm. The "RESTRAINT RISK RE-ASSESSMENT" section indicated the device was not considered as a restraint but as an enabler due to it did not prevent the resident from doing something they could previously do and/or it did not restrict movement and/or the resident can remove the device upon request. Also, the "IDT (Interdisciplinary team) REVIEW" section, which was dated 3/21/11, indicated to continue alarms per assessment. The resident's safety awareness continued to be an issue frequently. 2. On 6/27/11 at 1:50 p.m., Resident #6 was observed in the TV area in a recliner. The foot of the recliner was being held up by a wastebasket. On 6/27/11 at 3:05 p.m. during an interview, LPN #4 indicated the wastebasket was to keep Resident #6's feet up higher. At this same time, LPN #5 indicated the wastebasket could be considered a restraint due to the difficulty with the wastebasket to get out of the chair.		seat belt on command. This audit will occur daily x 2 weeks, weekly x 2 weeks, then monthly until substantial compliance is met. The defective recliner has been discarded.Results of the audits will be presented to the Quality Assurance Committee on a monthly basis until consistent application of the guidelines are noted. Periodic evaluation will be conducted for following applicable guidelines.	

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	On 6/28/11 at 3:30 p.m., Resident #6 was observed in the TV area by the nurse's station sitting in a recliner. The foot of the recliner was being held up by a wastebasket. Resident #6's record was reviewed on 6/27/1 at 10:30 a.m. The resident's diagnoses included, but were not limited to, organic brain syndrome and hydrocephalus. The quarterly minimum data set assessment, dated 5/10/11, indicated the resident made poor decisions requiring supervision. 3. The "GUIDELINES FOR RESTRAINT/ENABLER USE" policy was provided by the Director of Nursing on 6/30/11 at 8:30 a.m. This current policy indicated the following: "Purpose: To ensure completion of assessment and evaluation for appropriate and safe use of restraints. Procedure: ...6. The determination of whether a device is or is not a restraint is based on an individualized, assessment of the resident. The assessment identifies the specific medical symptom and evaluates the risks and benefits and the purpose being considered for the use of a device or			

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	practice. The determination must include whether the resident is capable of independently removing the device and whether the device restricts the resident's freedom of movement. The answers to these questions will vary with the individual resident situation. ...8. Considerations for determining whether the device is a restraint or an enabler: a. If the device does NOT restrict the resident from doing something they could previously do AND assists the resident's function to a higher level, it is an ENABLER, NOT a restraint. b. If a device restricts the resident from doing something they could previously do BUT allows a resident to function at a higher level, it is an enabler AND a restraint. In this case the restraint protocol must be followed. c. If a device restricts the resident from doing something they could previously do and does NOT assist the resident to function at a higher level, it is a restraint and may be used for a limited timeframe....." 3.1-29(o)			

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F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse for 1 of 1 resident reviewed for allegations of abuse in a sample of 15. (Resident # 47) Findings Include: On 6/27/11 at 8:45 a.m., during interview, Resident # 47's daughter indicated on 6/26/11 sometime after lunch she came into the facility after her father had fallen and he was sitting in his wheelchair in the lounge. As she walked up the hallway, she heard LPN # 10 yelling at her father from the nurses station to get back into his wheelchair and to sit down. She indicated she felt the nurse was "mad" at her father because he had fallen and they were sending him to the hospital. She indicated QMA # 9 had heard LPN # 10 yelling at her dad. The daughter indicated she had spoke with Social Worker (SW) # 11 on that day and informed her of the situation and she indicated the SW had filled out a form.	F0223	#1 Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: The investigation was initiated on 6/26/11. The Administrator was notified of the allegation of abuse on 6/28/11. The employee was suspended on 6/28/11 pending investigation and the initial report was sent to the ISDH via fax on 6/27/11. The investigation was completed and the allegation of abuse was unsubstantiated related to the the employee did not have the willful intent to inflict mental anguish to this resident. The employee raised her voice to the resident,who was across the room, in an effort to prevent him from falling due to he was attempting to stand up from his wheelchair. The employee returned to work with counseling regarding customer service and 1:1 inservicing on campus guidelines for abuse, stress and burnout, and appropriate ways to communicate with residents who are hard of hearing. A follow up report was sent to the ISDH via fax. #2 - Identification of other residents having the potential to be affected by the same alleged	07/30/2011

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	Review of a "Resident Concern Form" dated 6/26/11 at 1 p.m., completed by SW # 11 indicated the resident's daughter had came in to see the SW after her father had returned from the hospital. She informed the SW that she had heard LPN # 10 yelling at her father. She indicated she had heard this nurse make derogatory statements in the past and had heard her mumble under hear breath when caring for her father. The daughter indicated if the nurse would speak to a resident in that tone in front of people, what might she do when no one was around. A written form dated 6/26/11 was provided by the Director of Nursing on 6/30/11 at 8:40 a.m. The form was a typed paper signed by the SW. The form indicated she had spoken to QMA # 9 on 6/26/11 and the QMA had informed her she heard LPN # 10 "yelling" at the resident to stop and sit down. She further indicated she felt the LPN was "harsh" with the resident. The form indicated she had spoken to the LPN # 10 and the LPN indicated she had only raised her voice because the resident was hard of hearing. The Director of Nursing was informed and she informed the SW to start a grievance process and she would investigate in the morning. On 6/28/11 at 9 a.m. during interview,		deficient practice and corrective actions taken:All residents have the potential to be affected by this alleged deficient practice.#3 - Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will review campus guidelines with staff for Abuse and Neglect Procedures. #4 - How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will conduct resident interviews regarding staff treatment of residents. The interviews will be completed on 3 residents weekly x 4 weeks, then 3 residents monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the resident interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter.	

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	155698	A. BUILDING 00 B. WING	06/30/2011

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	QMA # 9 indicated that on 6/26/11 she had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse. on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She indicated she had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she had now interviewed everyone involved in the above event and the investigation was ongoing.			

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	A policy titled "Abuse and Neglect Procedural Guidelines" was provided by the Administrator on 6/27/11 at 10 a.m., and deemed as current. The policy indicated: "Purpose:...has developed and implemented processed, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Verbal Abuse-may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability...The shift supervisor or manager is identified as responsible for initiating and or continuing the reporting process, as follows:...immediately notify the Executive Director...completed Accident and Incident Report...The Executive Director is responsible for: 1. Notification of State Department of Health...and other agencies...Protection:..Suspend suspected employee(s) pending outcome of investigation...The Executive Director is accountable for investigating and reporting...." 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure an allegation of verbal abuse was thoroughly investigated and reported the appropriate agencies timely for 1 of 1 resident reviewed for	F0225	#1 Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: The investigation was initiated on 6/26/11. The Administrator was	07/30/2011

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	allegations of verbal abuse in a sample of 15. (Resident # 47) Findings include: On 6/27/11 at 8:45 a.m., during interview, Resident # 47's daughter indicated on 6/26/11 sometime after lunch she came into the facility after her father had fallen and he was sitting in his wheelchair in the lounge. As she walked up the hallway, she heard LPN # 10 yelling at her father from the nurses station to get back into his wheelchair and to sit down. She indicated she felt the nurse was "mad" at her father because he had fallen and they were sending him to the hospital. She indicated QMA # 9 had heard LPN # 10 yelling at her dad. The daughter indicated she had spoke with Social Worker (SW) # 11 on that day and informed her of the situation and she indicated the SW had filled out a form. Review of a "Resident Concern Form" dated 6/26/11 at 1 p.m., completed by SW # 11 indicated the resident's daughter had came in to see the SW after her father had returned from the hospital. She informed the SW that she had heard LPN # 10 yelling at her father. She indicated she had heard this nurse make derogatory statements in the past and had heard her mumble under hear breath when caring		notified of the allegation of abuse on 6/28/11. The employee was suspended on 6/28/11 pending investigation and the initial report was sent to the ISDH via fax on 6/27/11. The investigation was completed and the allegation of abuse was unsubstantiated related to the the employee did not have the willful intent to inflict mental anguish to this resident. The employee raised her voice to the resident,who was across the room, in an effort to prevent him from falling due to he was attempting to stand up from his wheelchair. The employee returned to work with counseling regarding customer service and 1:1 inservicing on campus guidelines for abuse, stress and burnout, and appropriate ways to communicate with residents who are hard of hearing. A follow up report was sent via fax to the ISDH#2 - Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:All residents have the potential to be affected by this alleged deficient practice.#3 - Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will review campus guidelines with staff for Abuse and Neglect Procedures. #4 - How the corrective measures will be monitored to ensure the	

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	for her father. The daughter indicated if the nurse would speak to a resident in that tone in front of people, what might she do when no one was around. A written form dated 6/26/11 was provided by the Director of Nursing on 6/30/11 at 8:40 a.m. The form was a typed paper signed by the SW. The form indicated she had spoken to QMA # 9 on 6/26/11 and the QMA had informed her she heard LPN # 10 "yelling" at the resident to stop and sit down. She further indicated she felt the LPN was "harsh" with the resident. The form indicated she had spoken to the LPN # 10 and the LPN indicated she had only raised her voice because the resident was hard of hearing. The Director of Nursing was informed and she informed the SW to start a grievance process and she would investigate in the morning. On 6/28/11 at 9 a.m. during interview, QMA # 9 indicated that on 6/26/11 she had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset. On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse.		alleged deficient practice does not recur: DHS or designee will conduct resident interviews regarding staff treatment of residents. The interviews will be completed on 3 residents weekly times 4 weeks, then 3 residents monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the resident interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter.	

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	on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She indicated she had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event. On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had now been suspended pending investigation. She indicated she had now interviewed everyone involved in the above event and the investigation was ongoing. This was two days after the alleged event of verbal abuse. A faxed Incident Report form dated and timed 6/28/11 at 3:07 p.m., provided by the Director of Nursing on 6/29/11 at 2:30 p.m., indicated the allegation of verbal abuse had been reported to the Indiana State Department of Health. This was 2 days after the event.			

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	A policy titled "Abuse and Neglect Procedural Guidelines" was provided by the Administrator on 6/27/11 at 10 a.m., and deemed as current. The policy indicated: "Purpose:...has developed and implemented processed, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Verbal Abuse-may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability...The shift supervisor or manager is identified as responsible for initiating and or continuing the reporting process, as follows:...immediately notify the Executive Director...completed Accident and Incident Report...The Executive Director is responsible for: 1. Notification of State Department of Health...and other agencies...Protection:..Suspend suspected employee(s) pending outcome of investigation...The Executive Director is accountable for investigating and reporting...." 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their abuse policy by failing to immediately notify the Administrator of allegations of verbal abuse and failed to ensure an investigation was initiated timely and staff suspension at the time of the reported event for 1 of 1 resident reviewed for allegations of verbal abuse in a sample of 15. (Resident # 47) Findings include: On 6/27/11 at 8:45 a.m., during interview, Resident # 47's daughter indicated on 6/26/11 sometime after lunch she came into the facility after her father had fallen and he was sitting in his wheelchair in the lounge. As she walked up the hallway, she heard LPN # 10 yelling at her father from the nurses station to get back into his wheelchair and to sit down. She indicated she felt the nurse was "mad" at her father because he had fallen and they were sending him to the hospital. She indicated QMA # 9 had heard LPN # 10 yelling at her dad. The daughter indicated she had spoke with Social Worker (SW) # 11 on that day and informed her of the situation and she indicated the SW had	F0226	#1 Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: The investigation was initiated on 6/26/11. The Administrator was notified of the allegation of abuse on 6/28/11. The employee was suspended on 6/28/11 pending investigation and the initial report was sent to the ISDH via fax on 6/27/11. The investigation was completed and the allegation of abuse was unsubstantiated related to the the employee did not have the willful intent to inflict mental anguish to this resident. The employee raised her voice to the resident,who was across the room, in an effort to prevent him from falling due to he was attempting to stand up from his wheelchair. The employee returned to work with counseling regarding customer service and 1:1 inservicing on campus guidelines for abuse, stress and burnout, and appropriate ways to communicate with residents who are hard of hearing. A follow up report was sent via fax to the ISDH#2 - Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:All residents have the potential to be affected by this	07/30/2011

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	filled out a form. Review of a "Resident Concern Form" dated 6/26/11 at 1 p.m., completed by SW # 11 indicated the resident's daughter had came in to see the SW after her father had returned from the hospital. She informed the SW that she had heard LPN # 10 yelling at her father. She indicated she had heard this nurse make derogatory statements in the past and had heard her mumble under hear breath when caring for her father. The daughter indicated if the nurse would speak to a resident in that tone in front of people, what might she do when no one was around. A written form dated 6/26/11 was provided by the Director of Nursing on 6/30/11 at 8:40 a.m. The form was a typed paper signed by the SW. The form indicated she had spoken to QMA # 9 on 6/26/11 and the QMA had informed her she heard LPN # 10 "yelling" at the resident to stop and sit down. She further indicated she felt the LPN was "harsh" with the resident. The form indicated she had spoken to the LPN # 10 and the LPN indicated she had only raised her voice because the resident was hard of hearing. The Director of Nursing was informed and she informed the SW to start a grievance process and she would investigate in the morning.		alleged deficient practice.#3 - Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will review campus guidelines with staff for Abuse and Neglect Procedures. #4 - How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will conduct resident interviews regarding staff treatment of residents. The interviews will be completed on 3 residents, weekly x 4 weeks then 3 residents monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the resident interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter.	

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On 6/28/11 at 9 a.m. during interview, QMA # 9 indicated that on 6/26/11 she had heard LPN # 10 "screaming" at the resident. She indicated she felt the nurse was very inappropriate and if had of been her family she would have been upset.

On 6/28/11 at 9:50 a.m., during interview, the Administrator indicated he had not been informed of the above allegation of verbal abuse.

on 6/28/11 at 10:10 a.m., during interview, the Director of Nursing indicated she had been informed of the above event on 6/26/11 by the Social Worker. She indicated she had informed the SW to try to investigate the event. She indicated she did not consider this to be verbal abuse. She indicated she knows the nurse, and the nurse is hard of hearing and so was the resident. She indicated she did not consider it potential abuse. She had not notified the Administrator and LPN # 10 had not been suspended but had not worked since the event.

On 6/28/11 at 10:50 a.m., during interview, the Director of Nursing indicated LPN # 10 had been suspended pending investigation. She indicated she had now interviewed everyone involved in the above event and the investigation

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	was ongoing. A policy titled "Abuse and Neglect Procedural Guidelines" was provided by the Administrator on 6/27/11 at 10 a.m., and deemed as current. The policy indicated: "Purpose:...has developed and implemented processed, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Verbal Abuse-may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability...The shift supervisor or manager is identified as responsible for initiating and or continuing the reporting process, as follows:...immediately notify the Executive Director...completed Accident and Incident Report...The Executive Director is responsible for: 1. Notification of State Department of Health...and other agencies...Protection:...Suspend suspected employee(s) pending outcome of investigation...The Executive Director is accountable for investigating and reporting...." 3.1-28(a)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident did not receive medication which was not ordered by a physician and the resident did not have a medial condition which was treated by said medication; residents who were experiencing signs and symptoms of hypoglycemia or hyperglycemia received nursing services to address the condition and/or an assessment of the residents condition following abnormal blood sugar results and residents who had physician's orders for sliding scale insulin received insulin in accordance with the physician's order for 1 of 4 residents interviewed regarding the accuracy of medication administration in a sample of 15 (Resident #21) and 2 of 2 diabetic residents reviewed for diabetic services in a sample of 15 (Residents #52 & #44). Findings include: 1.) During a 6/28/11, 11:15 a.m., interview, Resident #21 indicated that a couple of weeks ago, LPN #12 came into the dining room, spoke to the resident and as she spoke to the resident she rolled up	F0309	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident #21 - corrective action was taken at the time of the medication error. Per guideline, Medication Error Circumstance form was complete, MD and family was notified, and nurse was counseled. Resident #52 and #44 assessed and display no sign/symptoms of hyper/hypoglycemia. Resident #52 record review and sliding scale insulin has been administered as ordered per MD.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice of not receiving medications as ordered by MD. Residents with accucheck orders records reviewed and noted no signs/symptoms of hyper/hypoglycemia currently. Residents with sliding scale insulin orders records reviewed past 7 days to ensure MD orders were followed.3. Measures put into place and systemic changes made to ensure the alleged	07/30/2011

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	the residents shirt sleeve. The resident indicated she did not understand what the nurse said and stated "what?" The Resident #21's tablemate said "She doesn't get insulin. She's not diabetic!" Resident #21 realized what was happening and stated "I do not get insulin." As she was stating the fact that she did not get insulin, LPN #12 gave her an insulin injection. LPN #12 reassured Resident #21 that yes she did get insulin at supper time and left the area. LPN #13, who the resident knew well, entered the area. At this time Resident #21 asked if the doctor had put her on insulin. LPN #13 indicated no and inquired why the resident was asking the question. When Resident #21 indicated she had just been given a shot of insulin, LPN #13 acted quickly, investigated what had happened and spoke to the doctor. During this time, another employee had Resident #21 drink an ensure to get additional food and sugar into her system. That evening the nurses checked her blood sugar a number of times. She had not gotten sick because the nurses acted quickly. Resident #21 indicated she later found out the error occurred because LPN #12 was newer and Resident #21 had a similar last name to another resident. Resident #21 additionally indicated that maybe a week following the above incident another nurse approached her and wanted to give her a shot for diabetes.		deficient practice does not recur: DHS or designee will review campus guidelines for Hyper/Hypoglycemia and Medication administration with licensed nurses and QMAs. 4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will conduct medication pass observation on 3 nurses or QMAs weekly x 4 weeks, then 3 nurses or QMAs monthly x 5 months to ensure compliance. The observations will then be conducted randomly as needed thereafter. The results of the med pass observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter. The medication pass observations will occur on all 3 shifts. DHS or designee will conduct audit of medication administration records for residents with accuchecks to ensure signs/symptoms of hyper/hypoglycemia is assessed with intervention and assessment after intervention documented. DHS or designee will conduct audit of medication administration records (MAR) for all residents with sliding scale insulin orders to ensure and that sliding scale insulin is administered as ordered per MD. The audits will be conducted on all residents with	

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	She indicated she stated a firm no and you have the wrong person. At this time, a CNA stated you have the wrong person, Resident #21 was not diabetic. The nurse stopped what she was doing and went to the station to clarify the situation. 2.) Resident #21's record was reviewed on 6/27/11 at 3:00 p.m. Resident #21's current diagnosis included, but were not limited to, atrial fibrillation and hypertension. The resident did not have a diagnoses of diabetes or receive any form of insulin. Resident #21 had a current, 5/11/11, Minimum Data Set assessment which indicated the resident was alert, reliable and had intact decision making skills. Review of a 6/20/11, facility "Medication Error Circumstance, Assessment and Interview" form indicated Resident #21 had receive 4 units of Humalog insulin which was ordered for another resident. 3.) During a 6/28/11, 3:05 p.m., interview, LPN #12 indicated she had administered insulin to Resident #21 on 6/15/11 in error because Resident #21's last name was pronounced the same as another resident's last name. She indicated she had misunderstood who the		sliding scale insulin orders 3 times per week x 4 weeks, , then monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter.	

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	resident was and gave Resident #21 another resident's medication. She said following the administration Resident #21 indicated she did not get insulin and LPN #12 went to check the medication administration record and order. She indicated she believed Resident #21 might not remember her medications correctly. While she was checking the record, LPN #13, who was Resident #21's nurse, approached her explained the error of misidentification and took over the situation by calling Resident #21's physician etc. She indicated she had been re-educated following the error and would always examine the resident's photograph, which was located in the medication administration record, closely prior to administering any medication. During a 6/28/11, 2:30 p.m., interview the Director of Nursing indicated, LPN #12 had been re-educated and received a written warning following the medication administration error with Resident #21. She indicated the second error which almost occurred shortly thereafter, was actually the employee wanting to give the resident an accucheck in error, due once again to misidentification. She indicated that following that event on 6/21/11 all nurses and QMAs were given a medication administration inservice to address misidentification and the			

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	photograph system which was in place. 4.) Resident #52's record was reviewed on 6/27/11 at 10:45 a.m. Resident #52's current diagnoses included, but were not limited to, diabetes mellitus, hypertension. Resident #52 was admitted to the facility on 6/15/11. Resident #52 had current, 6/15/11, physician's orders for: a.) accuchecks (blood sugar checks) before breakfast, before lunch, before supper and at bedtime. b.) notify the physician if the resident's blood sugar results was less than 60 or greater than 400. c.) administer Novolg insulin following the accuchecks in accordance to sliding scale (administration of insulin in various doses in relation to the obtained blood sugar results). 121 to 150 = 4 units 151 to 200 = 6 units 201 to 250 = 8 units 251 to 300 = 12 units 301 to 350 = 16 units 351 to 400 = 20 units 401 to 999 = 20 and call physician			

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	d.) glucagon 1 mg hypokit-inject 1 mg as needed for signs or symptoms of hypoglycemia (low blood sugar) if unable to swallow. A review of Resident #52's accucheck record and nursing notes indicated the following incidents of low blood sugar when the doctor was not notified and the resident was not assessed or administered treatment to address low blood sugars such as eating a food containing carbohydrates or administering glycogen: a.) 6/16/11 before breakfast a result of 52. b.) 6/16/11 before supper a result of 44. c.) 6/18/11 before supper a result of 49. d.) 6/22/11 before breakfast a result of 50. e.) 6/22/11 before supper a result of 51. Resident #52 had accuchecks with documented insulin administration or lack thereof which were not consistent with physician's orders: a.) 6/26/11 before breakfast a result of 131 with documentation of zero insulin given. The 131 result required 4 units of insulin to be given per sliding scale orders. b.) 6/28/11 before break a results of 128 with documentation of zero insulin being given. The 128 result required 4 units of insulin to be given per sliding scale orders.			

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	5.) During a 6/29/11, 1:40 p.m., interview, the Director of Nursing indicated the facility did not have any documentation or additional information to provided regarding the doctor being notified of the above low blood sugars, Resident #52 being assessed and offered nursing services or treatment when her blood sugar was low. She did not believe the doctor had been notified as she did not know if the resident received any nursing services with the blood sugar was low. Additionally the above sliding scale insulin administrations appeared to be an error when the order was not followed and the resident did not receive insulin per sliding scale. 6. The record for Resident # 44 was reviewed on 6/29/11 at 10 a.m. Current diagnoses included, but were not limited to, Diabetes. Physician orders for June 2011 indicated the physician was to be notified of blood sugar results less than 70 and greater than 400. Original date of order was 7/23/10. A plan of care last reviewed 5/11 indicated a problem of diabetes with approaches that included, but were not limited to, report significant assessment data to the physician and observe and report sign and symptoms of			

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	hyperglycemia: polyuria, polyphagia, polydipsia, abdominal pain, nausea and vomiting and increased respirations. The Medication Administration Record for April, May, and June 2011 indicated the following blood sugar results and the record lacked follow-up assessments for signs and symptoms or follow-up blood sugar. April 1 at supper blood sugar was 424. May 12 at supper blood sugar was 425. May 26 at supper blood sugar was 455. June 11 at supper blood sugar was 422. June 14 at supper blood sugar was 462. June 16 at supper blood sugar was 497. June 24 at supper blood sugar was 418. On 6/29/11 at 9:30 a.m., additional information was requested from the Assistant Director of Nursing regarding the lack of follow-up assessment of the resident with high blood sugars. On 6/29/11 at 2:30 p.m., during interview, the Assistant Director of Nursing indicated she was unable to provide any additional information regarding follow-up assessment of the high blood sugars. 7. A policy dated 11/8/2010 titled "Guidelines for Hyper/Hypoglycemia"			

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	was provided by the Director of Nursing on 6/29/11 at 9:55 a.m., and deemed as current. The policy indicated: "Purpose: To ensure appropriated medical treatment is provided to residents experiencing hyper/hypoglycemic episodes. All residents diagnosed with diabetes mellitus, will receive interventions according to their physician order. If the attending physician(s) have not provided specific orders on what treatment is to be provided to treat hypoglycemic episodes, the following guidelines will be followed until the attending physician can be contacted. Symptoms of hypoglycemia...1. tremors 2. tachycardia 3. anxiety 4. dizziness 5. headache 6. vision changes 7. altered mental capacity such as confusion or abnormal behaviors Symptoms of hyperglycemia...1. increased thirst 2. headache 3. difficulty concentrating 4. blurred vision 5. frequent urination 6. fatigue 7. weight loss...Blood glucose 50-69...give a 15-gram carbohydrate oral feeding of one of the following: *1 tube of glucose gel *4 ounces of any juice without adding sugar *4 ounces of regular soda pop *8 ounces of low-fat/nonfat milk wait 15 minutes and recheck blood sugar. If resident continues to have a hypoglycemic symptoms or blood sugar <70 (less than), repeat 15 gram carbohydrate oral feeding Recheck blood sugar every 15			

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	minutes...until symptoms are resolved...." 3.1-37(a)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review, observation and interview, the facility failed to ensure a resident with skin impairment had preventative measures implemented to ensure further skin breakdown would not occur for 1 of 2 residents reviewed for skin impairment in a sample of 15. (Resident # 60) Findings include: The record for resident # 60 was reviewed on 6/27/11 at 10:45 a.m. Current physician orders for June 2011 indicated an order for a foot cradle to be on bed at all times to keep pressure off of the left great toe. The original date of the order was 2/18/10. The orders also indicated an order for an anchored	F0314	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident #60 was immediately assessed after being made aware of the alleged deficiency. Noted that resident's wounds had not changed from her most recent assessment. Bed and foot cradle were in place and catheter tubing was appropriately placed. Foot cradle was added to the CNA assignment sheet in bold lettering.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All resident's with skin impairment were observed to ensure all preventative measures, per care plan, were in place.3. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or	07/30/2011

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	catheter. A "Change in Condition Form" dated 6/27/11 at 9:45 a.m., indicated the resident had "marks from ac (anchored catheter) on (L with a circle around it) left leg and the physician had ordered a barrier cream. Skin impairment sheets dated 6/27/11 indicated the resident had a 4 centimeter (cm) by 0.2 cm brown line, a 7 cm by 0.2 cm brown line, a 4 cm by 0.2 cm brown line and a 12 cm by 0.2 cm brown line on the left posterior thigh. During a wound treatment observation on 6/28/11 at 1:38 p.m., with LPN #18, Resident # 60 was in bed, her anchored catheter tubing was positioned under her left thigh. The LPN was informed of this at the time and positioned the anchored catheter tubing over the top of the resident's left thigh. The areas to the left thigh remained unopened at the time of the observation. After the LPN completed a treatment to an abrasion on the 2nd and 3rd left toes, she covered the resident with a sheet and a blanket laying directly on top of the residents left foot. The LPN exited the room and did not apply the foot cradle. On 6/28/11 at 2:05 p.m., Resident # 60		designee will review campus guidelines for Preventative measures for skin with nursing staff. 4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will conduct audit of residents with skin impairment to ensure preventative measures are in place per the resident's plan of care. The audits will be completed on all residents with skin impairment 3 times per week x 4 weeks, then all residents with skin impairment monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the skin impairment audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter.	

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	was in bed and the foot cradle was not on the bed. The sheet and blanket remained on the resident's feet. On 6/28/11 at 3:20 p.m., Resident # 60 was in bed and the foot cradle was not on the bed. At that time, during interview, LPN #3 was informed the foot cradle was not on the bed. She indicated the cradle should be on the bed and applied it at that time. 3.1-40(a)(2)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure anchored catheter tubing and drainage bag was positioned in a manner to prevent the possibility of infection for 3 of 3 residents reviewed for proper placement of anchored catheter tubing and drainage bag in a sample of 15. (Resident # 60, # 59 and # 54)	F0315	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident #60 observed and proper placement of drainage bag noted during transfer. Resident #59, and #54 catheter tubing observed to not be touching the floor during transfer and while seated in w/c. CNA #14 and #15 were immediately	07/30/2011

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	Findings include: 1. The record for resident # 60 was reviewed on 6/27/11 at 10:45 a.m. Current diagnosed included, but were not limited to, neurogenic bladder. Current physician orders for June 2011 indicated the resident had an anchored catheter. A plan of care last reviewed in 4/11, indicated the resident had an indwelling catheter and the drainage bag was to be maintained below the level of the bladder. During a care and transfer observation on 6/27/11 at 11:20 a.m., CNA # 14 and # 15 entered the resident's room. They placed a hoyer pad under the resident. CNA # 14 then placed the anchored catheter drainage bag and tubing on the resident's stomach in the bed. There was urine in the bag and tubing. The CNA asks the resident to hold onto the hook of the anchored catheter which she does. During the transfer the anchored catheter drainage bag and tubing remained on the resident's stomach above the level of the bladder. 2. The record for resident # 59 was reviewed on 6/28/11 at 2:30 p.m.		educated by DHS regarding proper placement of urinary drainage bag during transfer.#2 - Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents with catheters observed to ensure proper placement of drainage bag and tubing during transfer and while seated in w/c. 3. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will review campus guideline of Catheter Care with the nursing staff.4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will conduct observation on all residents with catheters to ensure proper placement of drainage bad and tubing during transfers and while seated in w/c. The observations will be completed 3 times per week x 4 weeks, then all residents with catheters monthly x 5 months to ensure compliance. The observations will then be conducted randomly as needed thereafter. The results of the observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter. The observations will occur on all 3 shifts.	

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Current diagnoses included, but were not limited to urinary retention.

Admission orders for June 2011 indicated the resident had an anchored catheter.

On 6/30/11 at 8:10 a.m., the resident was sitting in the main dining room in her wheelchair. Her anchored catheter tubing was on the floor under her wheelchair. At that time, RN # 17 was informed the tubing was on the floor. She then adjusted the tubing so it would not be on the floor.

3. On 6/27/11 from 11:40 a.m. to 11:55 a.m., Resident #54's transfer was observed. After CNA #1 and LPN #3 prepared the resident for her transfer, the resident was transferred from her bed to the wheelchair. During this transfer the resident's foley catheter tubing was dragging on the floor. Yellow, cloudy urine with white sediment was observed in the foley catheter tubing.

On 6/28/11 from 1:10 p.m. to 1:25 p.m., Resident #54's transfer was observed. After CNA #8 and QMA #9 prepared the resident for her transfer, the resident was transferred from her wheelchair to the bed. During this transfer, the resident's foley catheter tubing was observed to be dragging on the floor. Yellow, cloudy

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	urine with white sediment was observed in the foley catheter tubing. At this same time, CNA #8 indicated the foley catheter tubing should not touch the floor, and she should had been sure all of the tubing was in the dignity bag prior to the transfer. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident with aphasia and debility. The admission minimum data set assessment, dated 3/08/11, indicated the resident made poor decisions requiring supervision. The resident had an indwelling catheter. The physician order, dated 3/07/11, was Nitrofurantoin-mono (Macrobid) 100 milligram give 1 capsule by mouth every bedtime for chronic sepsis. The monthly nursing assessment, dated 6/03/11, indicated the foley catheter was due to urinary retention. 4. The "CATHETER CARE (INDWELLING CATHETER)" policy was provided by the Director of Nursing on 6/29/11 at 8:45 a.m. This current policy indicated the following: "Purpose 1. To prevent infection			

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	2. To reduce irritation ...* Additional infection control measures: a. Make sure the catheter is below the level of the bladder. ...c. Keep the catheter tubing away from the floor...." 3.1-41(a)(2)			
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review, and interviews, the facility failed to ensure a resident's oxygen was regulated by licensed personnel for 1 of 1 resident observed in a sample of 15. (Resident #16) Findings include: 1. On 6/27/11 from 11:25 a.m. to 11:40 a.m., Resident #16's transfer was observed	F0328	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: DHS immediately educated CNA #2 regarding the need for a licensed nurse to turn on oxygen for any resident. Resident #16 oxygen was set at the flow rate per MD order.#2 - Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All	07/30/2011

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	by CNA #1 and CNA #2. After the resident's transfer from her bed to her chair using the Hoyer lift was completed, CNA #2 was observed to put the resident's nasal canula in place and turn the portable oxygen on. At this same time during an interview, CNA #1 And CNA # 2 both indicated the resident's oxygen was regulated at 2 liters per minute. The resident was then transferred to the dining room for lunch. On 6/30/11 at 8:40 a.m. during an interview, CNA #1 indicated after positioning an oxygen canula on a resident, she would set the oxygen flow to the proper liters. On 6/30/11 at 8:45 a.m. during an interview, the Director of Nursing (DON) indicated only licensed personnel, not CNA's, were to regulate a resident's oxygen flow rate. 2. Resident #16's record was reviewed on 6/29/11 at 8:55 a.m. The resident's diagnoses included, but were not limited to, dysphasia, dementia, pneumonia, and left sided hemiparesis. The physician order, dated 1/28/11, was oxygen at 2 liters per minute continuously per nasal canula.		residents who receive oxygen have the potential to be affected by the same alleged deficient practice.3. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will review campus guidelines for Administration of Oxygen with nursing staff.4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will conduct observation audit on CNA caring for residents with oxygen to ensure the campus guidelines for oxygen administration are followed. The audits will be completed on 5 residents receiving oxygen weekly x 4 weeks, , then 5 residents monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter. The observations will occur on all 3 shifts.	

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	3. The "GUIDELINES FOR ADMINISTRATION OF OXYGEN" policy was provided by the DON on 6/30/11 at 12:20 p.m. At this same time during an interview, the DON indicated the policy did not specify the licensed nurse should regulate the oxygen flow but the policy should. 3.1-47(a)(6)			
F0329 SS=E	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record reviews and interviews, the facility failed to ensure residents receiving psychoactive medications had gradual dosage reductions and/or statements of contraindication related to	F0329	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: The MD will be contacted for Resident #51, #6, #54 and #44 and request	07/30/2011

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	the denial of a gradual dosage reduction for 4 of 4 residents reviewed for gradual dosage reductions in a sample of 15. (Resident #'s 51, 6, 54, and 44) Findings include: 1. Resident #51's record was reviewed on 6/27/11 at 2:15 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia with hallucinations/delusions. The pharmacy recommendation, dated 9/20/10, was to decrease Klonopin 0.5 mg twice daily to Klonopin 0.25 mg by mouth 2 times a day. The physician's orders, dated 9/29/10, were to discontinue the previous Klonopin 0.5 mg and to start Klonopin 0.25 mg 1 by mouth 2 times a day. The physician's order, dated 10/25/10, was Clonazepam (Klonopin) 0.5 mg (milligrams) give 1 tablet by mouth 2 times a day for anxiety, which was an increase from the prior dose. The record lacked any information of increase behaviors. The "PRN (AS NEEDED) MEDICATION TRACKING" records for 9/10 and for 10/10 indicated no additional Klonopin was administered.		a statement of contraindication related to their last denial of a gradual dose reduction. #2 - Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents on psychoactive medications have the potential to be affected by this same alleged deficient practice. During their next gradual dose reduction review, will request a statement of contraindication if the MD disagrees with the recommendations.3. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS met with Medical Director. He assisted with developing a new procedure for obtaining statements of contraindication related to the denial of a gradual dose reduction. Statements of contraindications related to the denial of a gradual dose reductions will be added to each pharmacist recommendation prior to submitting to the MD for review.4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will audit all pharmacy recommendations every month related to gradual dose reductions to ensure the MD has included a statement of contraindication related to the denial of a gradual dose	

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	The "QUARTERLY ANTIPSYCHOTIC MONITORING AND GDR (GRADUAL DOSE REDUCTION)" record, dated 2/25/11, indicated the diagnosis was dementia with hallucinations. The attempted dose reduction date was 9/20/10. The behaviors were indicated as yelling out, wandered, and would get into other resident's belongings. No further information was indicated concerning behaviors or a possible GDR related to the medication, Klonopin. On 6/29/11 at 2:30 p.m. during the daily exit conference meeting, information was requested concerning Resident #51's Klonopin use/rationale. On 6/30/11 at 8:45 a.m. during an interview, the Director of Nursing indicated she had no further information concerning Resident #51's behaviors and/or physician's rationale for denial of drug reduction. 2. Resident #6's record was reviewed on 6/27/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, organic brain syndrome, sleep apnea, insomnia, and hydrocephalus. The physician order, dated 10/29/09, was Trazodone (Desyrel) 50 milligrams (mg)		reduction. Any recommendations found to be incomplete will be re-submitted to the MD for corrections. These audits will be completed each month to ensure compliance and reported thru the campus Quality Assurance Committee.	

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	give 1/2 tab (25 mg) by mouth every bedtime for insomnia. The "QUARTERLY ANTIPSYCHOTIC MONITORING AND GDR (GRADUAL DOSE REDUCTION)" record, dated 10/08/11, indicated the diagnosis was insomnia. The Interdisciplinary Risk Management Team recommended "drug holiday" with 9 days on and 1 day off. The pharmacy recommendations, dated 10/21/10 and 4/14/11, indicated it was time to consider a dosage reduction for Desyrel 25 mg at bedtime. The physician had disagreed on each recommendation with no rationale given for the denial. On 6/29/11 at 2:30 p.m. during the daily exit conference meeting, information was requested concerning Resident #6's Desyrel use/rationale. 3. Resident #54's record was reviewed on 6/27/11 at 3:35 p.m. The resident's diagnoses included, but were not limited to, insomnia. The physician's order, dated 10/21/09, was Lunesta 2 milligrams (mg) by mouth every bedtime for insomnia. The "QUARTERLY ANTIPSYCHOTIC MONITORING AND GDR (GRADUAL			

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	DOSE REDUCTION)" record, dated 7/05/10, indicated the diagnosis was insomnia. The last attempted drug reduction was 4/20/10 and was unsuccessful. The Interdisciplinary Risk Management Team recommended to request a GDR per pharmacy's recommendations. The pharmacy recommendations, dated 10/21/10 and 4/14/11, indicated it was time to consider a dosage reduction for Lunesta 2 mg at bedtime. The physician had disagreed on each recommendation with no rationale given for the denial. On 6/29/11 at 2:30 p.m. during the daily exit conference meeting, information was requested concerning Resident #54's Lunesta's use/rationale. On 6/29/11 at 10:25 a.m. during an interview, the Director of Nursing indicated concerning Resident #'s 6, 54, and 44 she did not have any statements from the physicians concerning contraindications related to the decline to accept a gradual drug reduction. 4. The record for Resident # 44 was reviewed on 6/29/11 at 10 a.m. The June 2011 physician orders indicated an order for Remeron 15 milligrams daily at bedtime for depression. The original			

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	date of the order was 7/8/10. A plan of care last reviewed 5/11 indicated the resident utilized an antidepressant and interventions included, but were not limited to, work with physician/pharmacy to provide lowest therapeutic dosage. A "Note to Attending Physician/Prescriber" form from the pharmacist dated 9/7/10 indicated a recommendation to reduce the resident's Remeron and the resident's Lexapro. Both medications are used to treat depression. The form indicated the physician agreed to reduce the Lexapro but the Remeron was to stay at the same dose. No rationale was indicated why the Remeron was not reduced at this time. A "Note to Attending Physician/Prescriber" form from the pharmacist dated 3/9/11 indicated a recommendation to reduce the resident's Remeron. The physician had checked the disagree box but failed to indicate a rationale why the Remeron should not be reduced at this time. The Director of Nursing had also signed and dated the recommendation on 5/1/11. 5. A Policy titled "Unnecessary Medications" was provided by the			

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	Director of Nursing on 6/30/11 at 12:20 p.m., and deemed as current. The policy indicated: "...III. Contraindications to gradual Dose Reductions (GDR) will be based on the physician's determination that: a. A GDR would be likely to impair the resident's function or increase distressed behavior or cause psychiatric instability by exacerbation an underlying medical or psychiatric disorder. b. Continued use of the medication is in accordance with clinical standards and documentation per the physician gives clinical rational as to why a reduction is likely to impair function of psychiatric stability. c. The target symptom returned or worsened after the last reduction attempt and documentation per the physician gives clinical rational of the residents is (SIC) likely to experience impairment to function of psychiatric stability...." 3.1-48(b)(2)			

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure staffing was posted daily and in a timely manner for 3 of 4 days of the survey. This deficiency had the potential to impact 70 of 70 residents and visitors. (June 28, 29, and 30, 2011)	F0356	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: No residents were affected by this deficient practice.#2 - Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions	07/30/2011

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	Findings include: On 6/28/11 at 10:50 a.m., the staffing posted was for 6/27/11 (Monday). On 6/29/11 at 12:15 p.m., the staffing posted was for 6/28/11 (Tuesday). On 6/30/11 at 8:10 a.m., the staffing posted was for 6/28/11 (Tuesday). At this same time during an interview, the Assistant Director of Nursing indicated she would post the staffing. She also indicated she would usually have the information prepared the day before and place it in the frame kept at the nurse's station. 3.1-13(a)		taken: No residents were affected by this alleged deficient practice.3. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS will review the guidelines for required daily staff posting with the ADHS and weekend nursing managers.4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will audit/observe staff posting to ensure it is posted daily. The audit will be completed 5 times per week x 4 weeks, then monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audit will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter.	
F0365 SS=D	Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record review, observation, and interview, the facility failed to ensure food and liquids were served in the form ordered by the physician for 2 of 3 resident's reviewed for proper food and liquid texture in a sample of 13. (Resident # 60 and # 44) Findings include:	F0365	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident #60 whole hot dog removed and ground meat hotdog served when alleged deficiency noted. Resident #44 now receiving pre-thickened liquids.2. Identification of other residents having the potential to be affected by the same alleged	07/30/2011

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	1. The record for Resident # 60 was reviewed on 6/27/11 at 10:45 a.m. Physician orders for June 2011 indicated the resident was on a regular diet with ground meat. Original date of the order was 2/15/11. A plan of care dated 2/15/11 indicated a problem of resident not chewing meats and is at risk for choking. On 6/27/11 at 5:02 p.m., Resident # 60 was served her supper tray consisting of a whole hot dog on a bun. She was served by the Director of Nursing. At 5:12 p.m., the Resident attempted to cut up the hot dog but could not hold the knife tight enough. At 5:15 p.m., an unidentified dietary worker helped the resident with a clothing protector and cut up the hot dog. At that time, Dietary Aide # 19 was informed that Resident # 60 was to have ground meat. She indicated during interview at that time, the tray card did not have the resident identified as needing ground meat. At 5:21 p.m., the resident picked up a bite of the hot dog and began eating it. At 5:27 p.m., the Director of Nursing was informed the resident was to have a ground meat diet. She removed the resident's tray. At 5:30 p.m., the resident was served a ground meat hot		deficient practice and corrective actions taken: All residents with mechanically altered diets and thickened liquid orders have the potential to be affected by this same alleged deficient practice. Residents observed during meal time to ensure correct diet received. New powdered thickener was ordered with instructions for thickening liquids located directly on the can. Also, pre-thickened liquid has been ordered for staff use on medication carts.3. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager will review guidelines for reading tray cards and serving food in correct form with dietary staff. DHS or designee will review guidelines for reading tray cards, use of pre-thickened liquids, use of powdered thickener with instructions for thickening on the side of the can. 4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will audit thickened liquid orders to ensure correct consistency is served. Audit will be completed on 4 residents weekly x 4 weeks, , then 4 residents monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audits will be reported, reviewed and trended	

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	dog. 2. The record for resident # 44 was reviewed on 6/29/11 at 10 a.m. Current physician orders for June 2011 indicated the resident was to have nectar thick liquids. During a medication pass observation on 6/28/11 at 11:25 a.m., LPN # 3 prepared the resident water to drink by pouring thickener into the water from a plastic container. She did not measure the thickener. The water was pudding thick and would not pour from the cup as the resident tried to drink the water with her medication. At that time, during interview, LPN # 3 indicated she gauged the thickness by testing with a spoon. She indicated if the spoon stood up in the water it was honey thick. 3. A 2009 policy titled "Thickened Liquids" was provided by the Director of Nursing on 6/29/11 at 8:45 a.m., and deemed as current. The policy indicated: "...B. Nectar-thick liquids are easily pourable and are comparable to apricot nectar or thicker cream soups...5. If commercial thickeners are use, the manufacturer's instructions will be followed to ensure that the appropriate consistency is provided...."		for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter. Dietary Manager or designee will audit compliance in serving correct mechanically altered diets and correct reading of tray cards. Audit will be completed on all residents with order for mechically altered diet 3 x week x 4 weeks, , then all residents with order for mechanially altered diet monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter. The audits will include all 3 meals.	

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	4. A 2009 policy title "Sequence of Meal/Tray and Tray Cards" was provided by the Director of Nursing on 6/29/11 at 8:45 a.m., and deemed as current. The policy indicated: "...5. Tray card will be followed to ensure the correct diet is served...." 3.1-21(a)(3)			
F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observations, record review, and interview, the facility failed to ensure handwashing was completed in a manner to prevent the potential spread of infections and disease for 3 of 6 staff serving meals and for 2 of 2 observations in the 600 dining room and for 1 of 3 dining rooms observed. This deficiency had the potential to impact 19 of 70 residents eating daily in the 600 dining room. (CNA #2, Dietary server #6; CNA #7) (600 Dining room) Findings include: 1. On 6/27/11 from 11:58 a.m. to 12:40 p.m., lunch was observed. During this	F0371	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: Upon notification of this alleged deficient practice, all 600 hall dietary and CNA staff were inserviced regarding guidelines for hand washing, disposal of soiled paper towels and serving and clearing tables.2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents who eat in the 600 hall dining area have the potential to be affected by this same alleged deficient practice.3. Measures put into place and systemic changes made to ensure the alleged	07/30/2011

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	meal serving, CNA #2 was observed to put a hair net on from her pocket, enter the kitchen, and return with coffee 2 different times and ice water in a pitcher another time. No handwashing was observed during these trips in and out of the kitchen. 2. On 6/27/11 from 4:35 p.m. to 5:15 p.m., dinner was observed. While waiting on the remaining residents to come into the dining room for their meal, Dietary server #6 was observed to rinse the soiled dishes and then, load them into the dishwasher. Next, Dietary server #6 was observed to handwash for 12 seconds placing the used towels onto the top of a cart next to the handwashing sink. Then, she obtained a dessert tray of pudding from the refrigerator and the package of whipped cream. After the whipped cream was put on top of the pudding servings, she proceeded to serve the individual pudding servings. CNA #7 was observed to handwash in the kitchen and place her used paper towels on top of the same cart next to the handwashing sink. Dietary server #6 was observed to use handgel, entered the kitchen, and obtained a chocolate individual pudding and a vanilla individual pudding from the refrigerator. After serving these puddings to 2 different residents in the dining room, Dietary		deficient practice does not recur: Dietary Manager, DHS and designees will review campus guidelines for hand washing, disposal of soiled paper towels and protocol for serving and clearing tables with nursing and dietary employees.4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: Dietary Manager or designee will observe hand washing procedures in the 600 hall dining area for 3 employees 3 times per week x 4 weeks, , then 3 employees monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter. The audits will be conducted during all 3 meals served.	

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	server #6 was observed to throw trash away, scraped a plate off, entered the kitchen, and handwashed for less than 10 seconds placing the used towels on the same top shelf of a cart next to the handwashing sink. She, then, obtained a knife for a visitor to cut a sandwich, 2 individual glasses of ice water, and back out into the dining room passing desserts. CNA #7 was again observed in the kitchen, handwashed for 15 seconds, and placed the used paper towels on the cart next to the handwashing sink. At this same time during an interview, Dietary server #6 indicated one should handwash for 20 seconds and between the different activities, for example, picking up soiled dishes and serving food. She also indicated there was no wastebasket available in the kitchen next to the handwashing sink. 3. The "Hand Washing" policy was provided by the Director of Nursing on 6/29/11 at 8:45 a.m. This current policy indicated the following: "POLICY: Employees will use proper hand washing techniques to prevent the spread of infection. PROCEDURE: 1. All hands are washed:			

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	A. When entering the Nutrition Services Department. ...C. After handling soiled dishes and utensils. ...E. Before and after handling foods. ...2. Hand washing procedure: ...B. Add soap and rub well, especially between fingers and around and underneath fingernails for a minimum of 20 seconds. ...F. Use a paper towel to lift garbage can lid with hands to dispose of paper towels....." The "600 - Dining Room Seating Chart" was provided by the Director of Nursing on 6/30/11 at 8:30 a.m. Nineteen residents were indicated as eating in this dining room daily. 3.1-21(i)(2)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observations, interview, and record review, the facility failed to ensure infections control practices were following in a manner to prevent the potential for the spread of infections and	F0441	1. Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: Upon notification of the alleged deficient practice all nursing staff	07/30/2011

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	diseases concerning handwashing/glove use during personal care/transfer for 2 of 5 nursing staff observed (CNA #1; LPN #3) and for 2 of 2 residents observed (Resident #16 and #54) and concerning foley catheter handling during a transfer for 1 of 1 resident observed (Resident #60) and for 1 of 2 CNA's during the transfer (CNA #14), and concerning dressing changes for 1 of 2 nurses observed (LPN #18) for 1 of 2 residents observed (Resident #60). Findings include: On 6/27/11 from 11:25 a.m. to 11:40 a.m., Resident #16's personal care was observed. As the resident's brief was removed, CNA #1 indicated the resident had been incontinent of a small amount of loosely formed bowel movement. CNA #1 with gloved hands was observed to complete the resident's rectal care. With the same gloves, CNA #1 proceeded to redress the resident, assist the resident with moving her arms and hands from side rail to side rail as she was turned, assist with positioning the Hoyer sling under the resident before she removed her gloves. Next, she left the room and obtained the Hoyer lift from the hallway. After donning a new pair of gloves, the Hoyer sling was hooked to the Hoyer lift, and the resident was then transferred to		were inservice regarding facility guidelines on hand washing, glove use during care, catheter drainage bag and tubing placement, carrying treatments in and out of resident room and cleaning equipment prior to and after use for treatments.#2 - Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this same alleged deficient practice.3. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: DHS will review the following guidelines with nursing staff: All nursing staff was inserviced on the facility guidelines for hand washing, glove use during care, catheter drainage bag and tubing placement, carrying treatments into and out of rooms and cleaning of equipment before and after treatments. 4. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: DHS or designee will complete audits and observations regarding facility guidelines for infection control: Hand washing, glove use during care, catheter drainage bag and tubing, carrying treatments in and out of rooms and cleaning of equipment before and after use for treatments on 5 staff	

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	her chair. After CNA #1 made the resident's bed, she removed her gloves and readjusted the resident's bedside table before she was observed to handwash. On 6/27/11 from 11:40 a.m. to 11:55 a.m., Resident #54's transfer was observed. After the transfer from the resident's bed to her wheelchair was completed, LPN #3 was observed to remover her gloves and handwash for less than 15 seconds. During a care and transfer observation on 6/27/11 at 11:20 a.m., CNA # 14 and # 15 entered resident # 60's room. They placed a hoyer pad under the resident. CNA # 14 then placed the anchored catheter drainage bag and tubing on the resident's stomach in the bed. There was urine in the bag and tubing. The CNA asks the resident to hold onto the hook of the anchored catheter which she does. During the transfer the anchored catheter drainage bag and tubing remained on the resident's stomach above the level of the bladder. The resident had her hands on the anchored catheter bag and tubing. At the end of the observation, the Resident's hands were not washed. During a wound treatment observation on 6/28/11 at 1:38 p.m., with LPN #18, Resident # 60 was in bed. The LPN entered the room and placed a towel on		members 5 times per week x4 weeks, , then 5 staff members monthly x 5 months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The results of the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months, then randomly thereafter. The observations / audits will be completed on all 3 shifts.	

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	the bed with the dressing supplies including a bottle of wound cleanser, package of opened silver antimicrobial dressing and dressing supplies. She then washed her hands and donned gloves. She moved the towel to place it under the resident's left foot. The dressing supplies were directly on the residents bed at that time. After the wounds were cleansed she place the wound cleanser on the sheet by the resident's left foot. She then took scissors from her jacket pocket and placed them on the inside of the silver antimicrobial dressing package. She then cut the silver antimicrobial dressing to a size to fit the wound and places it on the abrasions on the resident's left 2nd and 3rd toes. She then placed the scissors on the opened telfa dressing. After dressing the wound with the telfa, she picked up the scissors and placed them back in her pocket. She picked up the wound cleanser bottle and the silver antimicrobial dressing package and placed it on the resident's dresser by the bathroom door so she could wash her hands. After exiting the room, LPN # 18 placed the wound cleanser and the silver antimicrobial dressing package back into the treatment cart. At that time during interview, she indicated she cleaned her scissors if she used them to cut off a soiled dressing. She also indicated the wound cleanser and silver dressing were reusable.			

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	Review of a facility provided, current, 01/11, policy titled "Handwashing Procedures Acknowledgement", which was provided by the Director of Nursing on 6/29/11 at 8:45 a.m., indicated the following: "Objective: 1. To remove transient microorganisms from HCW's [health care worker's] hands ...Wash well for 20 seconds, using rotary motion and friction." Review of a facility provided current, undated, policy titled, "Dressing Change (Clean)", which was provided by the Assistant Director of Nursing on 6/29/11 at 10:15 a.m., indicated the following: "Create clean field with paper towels or towelette drape." 3.1-18(b)(3) 3.1-18(l)			